Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos. 1210-0110 1210-0089

2017

This Form is Open to Public Inspection

Part I Annual Report Id	entification Information	•		•			
For calendar plan year 2017 or fisca	al plan year beginning 02/01/2017	and ending 01/31/2018					
A This return/report is for: a multiemployer plan a multiple-employer plan (Filers checking this box must atta participating employer information in accordance with the formation in accordance with accordance with the formation in accordance with the formation i							
	x a single-employer plan	a DFE (specify)					
B This return/report is:	the first return/report	the final return/report					
	an amended return/report	a short plan year return/report (less than 12 n	nonths))			
C If the plan is a collectively-barga	ined plan, check here			• 🗌			
D Check box if filing under:	Form 5558	automatic extension	the	e DFVC program			
	special extension (enter description)						
Part II Basic Plan Inform	nation—enter all requested informa	ation					
1a Name of plan THE ARC JACKSONVILLE			1b	Three-digit plan number (PN) ▶	501		
			1c	Effective date of pla 02/01/1982	an		
City or town, state or province,	r, if for a single-employer plan) apt., suite no. and street, or P.O. Bo country, and ZIP or foreign postal co		2b	Employer Identifica Number (EIN) 59-6209603	tion		
THE ARC JACKSONVILLE			2c	Plan Sponsor's tele number 904-355-0155	phone		
1050 N DAVIS ST JACKSONVILLE, FL 32209-6808		DAVIS ST DNVILLE, FL 32209-6808	2d	Business code (see instructions) 624100	9		

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature. Signature of plan administrator	08/13/2018 Date	SCOTT HOLT Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	08/13/2018	SCOTT HOLT
SIGN HERE	Signature of employer/plan sponsor Signature of DFE	Date	Enter name of individual signing as employer or plan sponsor Enter name of individual signing as DFE

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

Form 5500 (2017) v. 170203

	Form 5500 (2017)		Page 2	2							
3a	Plan administrator's name and address X Same as Plan Sponsor		age 2	<u>-</u>					3b Administrator's EIN 3c Administrator's telephone		
									nun	mber	
4	If the name and/or EIN of the plan sponsor or the plan name has changed si enter the plan sponsor's name, EIN, the plan name and the plan number from					d for t	his plan,	, 41	b EIN	1	
a c	Sponsor's name Plan Name							40	d PN		
5	Total number of participants at the beginning of the plan year								5		110
6	Number of participants as of the end of the plan year unless otherwise state 6a(2) , 6b , 6c , and 6d).	d (welfare pl	ans co	mple	ete on	ly line	s 6a(1) ,		I		
а(1) Total number of active participants at the beginning of the plan year							6	a(1)		110
a(2) Total number of active participants at the end of the plan year							6	a(2)		126
b	Retired or separated participants receiving benefits								6b		1
С	Other retired or separated participants entitled to future benefits								6с		2
d	Subtotal. Add lines 6a(2), 6b, and 6c								6d		129
е	Deceased participants whose beneficiaries are receiving or are entitled to re	eceive benefi	ts						6e		
f	Total. Add lines 6d and 6e								6f		129
g	Number of participants with account balances as of the end of the plan year complete this item)								6g		
h	Number of participants who terminated employment during the plan year wit less than 100% vested								6h		
7	Enter the total number of employers obligated to contribute to the plan (only								7		
8a	If the plan provides pension benefits, enter the applicable pension feature co	odes from the	e List o	of Pla	an Ch	aracte	eristics C	Codes i	n the i	nstructions:	
b	If the plan provides welfare benefits, enter the applicable welfare feature cod 4A 4B 4D 4E 4F 4Q	des from the	List of	Plar	n Cha	racter	istics Co	odes in	the in	structions:	
9a	Plan funding arrangement (check all that apply) (1) X Insurance	9b Plan (1)	benefi	1	angen nsurai	,	check al	ll that a	pply)		
	(2) Code section 412(e)(3) insurance contracts	(2)	^	-			n 412(e)	(3) ins	urance	e contracts	
	(3) Trust	(3)		4	rust		-46 41-				
10	(4) General assets of the sponsor Check all applicable boxes in 10a and 10b to indicate which schedules are a	(4) attached, and	d, whei				ets of the			ned. (See instruc	
	Pension Schedules		eral So			,				,	,
u	(1) R (Retirement Plan Information)	(1)]		(Fin	ancial In	ıformati	ion)		
	/2) MP (Multiamplayor Defined Benefit Blan and Cortain Manage	(2)		Ī	ı	(Fina	ancial Inf	formati	on – S	Small Plan)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan	(3)	X] _	<u>3</u> A	(Ins	urance Ir	nforma	tion)		
	actuary	(4)			С	(Sei	vice Pro	vider lı	nforma	ation)	

(5)

(6)

SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

(3)

D (DFE/Participating Plan Information)

G (Financial Transaction Schedules)

Part III	Form M-1 Compliance Information (to be completed by welfare benefit plans)						
2520.	11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.)						
11b Is the	plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)						
11c Enter the Receipt Confirmation Code for the 2017 Form M-1 annual report. If the plan was not required to file the 2017 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)							
Rece	ipt Confirmation Code						

Form 5500 (2017)

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Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

		pursuant to E	RISA section 103(a)(2)				Inspection
For calendar plan year 20°	17 or fiscal plan	year beginning 02/01/2017		and en	ding 01/3	1/2018	
A Name of plan THE ARC JACKSONVILL	.E				e-digit number (PN	N) •	501
C Plan sponsor's name a THE ARC JACKSONVILL		2a of Form 5500		-	oyer Identifica 6209603	ation Number (EIN)
		ning Insurance Contract Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance car STANDARD LIFE & ACCID							
/L) FIN	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ntract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
73-0994234	86355	13335	48		02/01/2017	7	01/31/2018
2 Insurance fee and compute descending order of the		tion. Enter the total fees and tota	ıl commissions paid. Li	st in line 3	the agents,	brokers, and ot	her persons in
(a) Total a	amount of comn	•		(b) To	otal amount	of fees paid	
		11583					
3 Persons receiving com	missions and fe	es. (Complete as many entries a	as needed to report all	persons).			
	(a) Name a	nd address of the agent, broker, o	•	m commiss	ions or fees	were paid	
MWL		PO BO) JACKS(K 14067 DN, MS 39236				
(b) Amount of sales ar	nd base	Fees	s and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose	е		(e) Organization code
	2894						3
	(a) Name a	nd address of the agent, broker, o	or other person to whor	n commiss	ions or fees	were paid	
MARK BAILEY		1200 PL	ANTATION ISLAND D AUGUSTINE, FL 32080	RIVE S		·	
(b) Amount of sales ar	nd base	Fees	s and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose	е		(e) Organization code
	8689						3
For Donomicals Doductio	n Ant Nation	see the Instructions for Form F	E00			Calaa	I.ila A (Farm FEOO) 2017

Schedule A (Form 5500)	2017	Page 2 – [1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>, </u>	code
(1)				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi- this report.	dual contrac	cts with each carrier may	be treated	I as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year er			5	
		tracts With Allocated Funds:				
-	а	State the basis of premium rates				
	_	otato dio suoio di promini rutos				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor				
	u	retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participat	ion guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶		-		
		(5) U guaranteed investment (4) U other 7				
				ı		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 7c(5)			
)				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).		İ	7d	
		Deductions:	Γ			
	•	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(3)			
		(4) Outer (specify below)	. / C (+)			
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		i	7f	

ı	Page	4

F	art	Welfare Benefit Contract Inform If more than one contract covers the same the information may be combined for repo employees, the entire group of such indivi	e group of employees of the orting purposes if such conti	racts are ex	perience-rated as a	unit. Where co	ontracts cover individual
8	Ben	efit and contract type (check all applicable boxes	s)				
	а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	. 🗄	v a	Supplemental ur	nemployment	h Prescription drug
	i	Stop loss (large deductible)	j HMO contract	k			I Indemnity contract
	'		<i>-</i> ⊔	, in	110 contract		I I indefinity contract
	m	Other (specify) PSMEDICAL/PHYSICIAN (JOPAY_COPAY				
0							
J		erience-rated contracts: Premiums: (1) Amount received		9a(1)			
	а	(2) Increase (decrease) in amount due but unpa					
		(3) Increase (decrease) in unearned premium re		9a(3)			_
		(4) Earned ((1) + (2) - (3))	· ·			9a(4)	
	b	Benefit charges (1) Claims paid					
		(2) Increase (decrease) in claim reserves		21 (2)			
		(3) Incurred claims (add (1) and (2))	· ·			9b(3)	
		(4) Claims charged					
	С	Remainder of premium: (1) Retention charges (on an accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes		9c(1)(E)			_
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)		1	
		(H) Total retention	_				!
		(2) Dividends or retroactive rate refunds. (Thes	e amounts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1) Amount held to provide	benefits afte	er retirement	` '	
		(2) Claim reserves					
		(3) Other reserves				· · · ·	
4.0	<u>е</u>	Dividends or retroactive rate refunds due. (Do	not include amount entered	in line 9c(2	2) .)	9e	
10	_	nexperience-rated contracts:				40-	5700
	а	Total premiums or subscription charges paid to					5792
	b Sne	If the carrier, service, or other organization incuretention of the contract or policy, other than recify nature of costs.					
P	art					П	
11	Di	the insurance company fail to provide any infor	mation necessary to compl	ete Schedu	le A?	Yes	X No
12	2 If t	he answer to line 11 is "Yes," specify the informa	ition not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

OMB No. 1210-0110

pursuant to ERISA section 103(a)(2).					This Fo	rm is Open to Public Inspection		
For calendar	plan year 201	7 or fiscal pla	in year beginning 02/01/2017		and er	nding 01/3	1/2018	
A Name of p	plan ACKSONVILL	E				e-digit n number (PN) >	501
•	nsor's name as		ne 2a of Form 5500		•	oyer Identifica -6209603	ation Number	(EIN)
Part I			rning Insurance Contract A. Individual contracts grouped a					
1 Coverage	Information:							
` '	insurance car N NATIONAL		ANCE COMPANY	L (a) Assessinate se		ī	Dollovor	
(b)	EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate not persons covered a policy or contract	t end of	(f)	From	(g) To
35-0472300		65676	0001D0258360000	73		02/01/2017	,	01/31/2018
	fee and comr g order of the		nation. Enter the total fees and tot	al commissions paid. L	st in line 3	the agents, I	orokers, and o	other persons in
	(a) Total a	mount of com	imissions paid		(b) T	otal amount o	of fees paid	
			2567		1		•	58
3 Persons r	eceiving comr	missions and t	fees. (Complete as many entries	as needed to report all	persons).			
			and address of the agent, broker,			sions or fees	were paid	
MFB FINANC	CIAL INC		1200 P STE 21	LANTATION ISLAND D	R			
(h) Amou	ınt of sales an	d hase	Fee	es and other commission	ns paid			
	nmissions pai		(c) Amount		(d) Purpos	е		(e) Organization code
		2567	58 BI	ROKER BONUS				3
		(a) Name	and address of the agent, broker,	or other person to who	n commiss	sions or fees	were paid	
(b) Amou	ınt of sales an	d base	Fee	es and other commission	ns paid			
	nmissions pai		(c) Amount		(d) Purpos	е		(e) Organization code
			 					

Schedule A (Form 5500)	2017	Page 2 – [1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>, </u>	code
(1)				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi- this report.	dual contrac	cts with each carrier may	be treated	I as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year er			5	
		tracts With Allocated Funds:				
-	а	State the basis of premium rates				
	_	otato dio suoio di promini rutos				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor				
	u	retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participat	ion guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶		-		
		(5) U guaranteed investment (4) U other 7				
				ı		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 7c(5)			
)				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).		İ	7d	
		Deductions:	Γ			
	•	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(3)			
		(4) Outer (specify below)	. / C (+)			
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		i	7f	

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Р	Part III Welfare Benefit Contract Information						
		If more than one contract covers the same the information may be combined for repor employees, the entire group of such individual.	ting purposes if such cont	racts are exp	perience-rated as a un	it. Where co	intracts cover individual
8	Ben	efit and contract type (check all applicable boxes)		-	<u> </u>	-	· · ·
	а	Health (other than dental or vision)	b X Dental	С	Vision		d Life insurance
	e [Temporary disability (accident and sickness)	- H	<u> </u>	Supplemental uner	nlovmont	h Prescription drug
				- 5		ipioyineni	
	י ו	Stop loss (large deductible)	j HMO contract	K	PPO contract		I Indemnity contract
	m	Other (specify)					
9		erience-rated contracts:			1		_
	а	Premiums: (1) Amount received		9a(1)			_
		(2) Increase (decrease) in amount due but unpair		9a(2)			_
		(3) Increase (decrease) in unearned premium res	•			02(4)	
	b	(4) Earned ((1) + (2) - (3))	i			9a(4)	
	D	(2) Increase (decrease) in claim reserves					_
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (c					
		(A) Commissions	· · · · · · · · · · · · · · · · · · ·	9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses					
		(E) Taxes					
		(F) Charges for risks or other contingencies.					_
		(G) Other retention charges		9c(1)(G)		1	
		(H) Total retention				9c(1)(H)	
	_	(2) Dividends or retroactive rate refunds. (These	_				
	d	Status of policyholder reserves at end of year: (1	· ·			` ` `	
		(2) Claim reserves				9d(2)	
	_	(3) Other reserves				9d(3)	
10	<u>e</u>	Dividends or retroactive rate refunds due. (Do n	ot include amount entered	in line 9c(2	<u>).)</u>	9e	
10	_	nexperience-rated contracts: Total premiums or subscription charges paid to o	oorrior			10a	2567
	a					10a	25674
	b	If the carrier, service, or other organization incur retention of the contract or policy, other than rep				10b	
	Spe	cify nature of costs.	ontod iii i dit i, iiio 2 doov	o, roport am	Odina		
Р	art	V Provision of Information					
11	Dic	the insurance company fail to provide any inform	nation necessary to compl	ete Schedul	e A?	Yes	X No
12	lf t	ne answer to line 11 is "Yes," specify the informat	ion not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

OMB No. 1210-0110

For calordar plan year 2017 or fiscal plan year beginning 0201/2017 and ending 01431/2018 A Name of plan THE ARC JACKSONVILLE Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A. 1 Coverage Information: (a) Name of insurance carrier THE LINCOLN NATIONAL LIFE INSURANCE COMPANY (b) EIN (c) NAIC (d) Contract or persons covered at end of policy or contract year of persons covered at end of policy or contract year of persons covered at end of policy or contract year of the amount paid. (a) To 1266 (a) Total amount of commissions paid (b) Total amount of fees paid 17 3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons.) (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code (e) Organization code (e) Organization paid (e) Organization pai	Insurance companies are required to provide the info pursuant to ERISA section 103(a)(2).						This Fo	rm is Open to Public Inspection	
C Plan sponsor's name as shown on line 2a of Form 5500 The ARC JACKSONVILLE Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A. 1 coverage Information: (a) Name of insurance carrier THE LINCOLN NATIONAL LIFE INSURANCE COMPANY (b) EIN (c) NAIC code identification number of code identification number of identification number of policy or contract year operation of the amount paid. (c) NAIC code identification number of policy or contract year operation of the amount paid. (a) Total amount of commissions information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid. (a) Total amount of commissions and fees. (Complete as many entries as needed to report all persons). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code (b) Amount of sales and base (c) Amount (d) Purpose (e) Organization code (b) Amount of sales and base Fees and other commissions or fees were paid (c) Amount (d) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base Fees and other commissions paid (c) Amount (d) Purpose (e) Organization code (b) Amount of sales and base Fees and other commissions paid (c) Amount of sales and base Fees and other commissions paid (c) Amount of sales and base Fees and other commissions paid	For calendar plan y	ear 2017 or fiscal p	plan year beginning 02/01/2017		and	ending 01/3	1/2018	1	
Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A. 1 Coverage Information: (a) Name of insurance carrier THE LINCOLN NATIONAL LIFE INSURANCE COMPANY (b) EIN (c) NAIC (d) Contract or identification number of persons covered at end of policy or contract year of identification number of policy or contract year of identification number of persons covered at end of policy or contract year of identification number of persons covered at end of policy or contract year of identification number of persons in information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid. (a) Total amount of commissions paid (b) Total amount of fees paid 17 3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid 1200 PLANTATION ISLAND DR SUNTE 210 SANT AUGUSTINE, FL 32080 (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code 1266 17 BROKER BONUS 3 (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid 1266 17 BROKER BONUS 3		ONVILLE				J	N) •	501	
on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A. 1 Coverage Information: (a) Name of insurance carrier THE LINCOLN NATIONAL LIFE INSURANCE COMPANY (b) EIN (c) NAIC code (d) Contract or identification number of persons covered at end of policy or contract year (b) EIN (c) NAIC code (d) Contract or identification number of persons covered at end of policy or contract year 2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid. (a) Total amount of commissions paid (b) Total amount of fees paid 1266 17 3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid MFB FINANCIAL INC 1206 PLANTATION ISLAND DR SUITE 210 SAINT AUGUSTINE, FL 32080 (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code 17 BROKER BONUS 3 (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base Fees and other commissions or fees were paid (c) Amount (d) Purpose (e) Organization code 17 BROKER BONUS 3			line 2a of Form 5500			•	ation Number	(EIN)	
(a) Name and address of the agent, broker, or other person to whom commissions paid (b) Amount of sales and base commissions paid (c) Amount of sales and base (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base (c) Amount of sales and base (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base (c) Amount (d) Amount of sales and base (e) Approximate number of persons covered at end of policy or contract year (e) Approximate number of persons covered at end of policy or contract year (f) From (g) To (g) To 20/01/2017 01/31/2018 (b) Total amount of cess paid (c) Amount of fees and other persons in descending order of the agent, broker, or other person to whom commissions or fees were paid (g) Amount of sales and base (g) Amount (g) Purpose (g) Organization code (g) Amount of sales and base (g) Amount (g) Purpose (g) Organization code	on a								
(b) EIN (c) NAIC code identification number persons covered at end of policy or contract year policy o	(a) Name of insura	ınce carrier	RANCE COMPANY						
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base (a) Name and address of the agent, broker, or other person to whom commissions paid (a) Name and address of the agent, broker, or other person to whom commissions paid (b) Amount of sales and base (c) Amount (d) Name and address of the agent, broker, or other person to whom commissions or fees were paid (e) Organization code (f) From (g) To (g) To 1260 127 128 129 170 170 181 182 183 184 185 185 185 185 185 185 185		(c) NAIO	(d) Contract or	. ,			Policy or o	contract year	
2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid. (a) Total amount of commissions paid (b) Total amount of fees paid 17 3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid MFB FINANCIAL INC 1200 PLANTATION ISLAND DR SUITE 210 SAINT AUGUSTINE, FL 32080 (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code 3 (b) Amount of sales and base and address of the agent, broker, or other person to whom commissions or fees were paid	(b) EIN	` '				(f)	From	(g) To	
descending order of the amount paid. (a) Total amount of commissions paid 1266 17 3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid MFB FINANCIAL INC 1200 PLANTATION ISLAND DR SUITE 210 SAINT AUGUSTINE, FL 32080 (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code 1266 17 BROKER BONUS 3 (b) Amount of sales and address of the agent, broker, or other person to whom commissions or fees were paid	35-0472300	65676	000010172458	126		02/01/2017	7	01/31/2018	
3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid MFB FINANCIAL INC 1200 PLANTATION ISLAND DR SUITE 210 SAINT AUGUSTINE, FL 32080 (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code 1266 17 BROKER BONUS 3 (b) Amount of sales and base				al commissions paid. Li	st in line	3 the agents, l	brokers, and	other persons in	
3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons). (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid 1200 PLANTATION ISLAND DR SUITE 210 SAINT AUGUSTINE, FL 32080 (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code 1266 17 BROKER BONUS 3 (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid	(a)	Total amount of co	ommissions paid		(b)	Total amount of	of fees paid		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid MFB FINANCIAL INC 1200 PLANTATION ISLAND DR SUITE 210 SAINT AUGUSTINE, FL 32080 (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code 1266 17 BROKER BONUS 3 (b) Amount of sales and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base Fees and other commissions paid (e) Organization code			1266					17	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid MFB FINANCIAL INC 1200 PLANTATION ISLAND DR SUITE 210 SAINT AUGUSTINE, FL 32080 (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code 1266 17 BROKER BONUS 3 (b) Amount of sales and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base Fees and other commissions paid (e) Organization code	3 Persons receiving	ng commissions an	d fees. (Complete as many entries	as needed to report all p	persons)				
SUITE 210 SAINT AUGUSTINE, FL 32080 (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code 1266 17 BROKER BONUS 3 (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base Fees and other commissions paid							were paid		
(c) Amount (d) Purpose (e) Organization code 1266 17 BROKER BONUS 3 (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base	MFB FINANCIAL IN	IC	SUITE	210					
commissions paid (c) Amount (d) Purpose (e) Organization code 1266 17 BROKER BONUS 3 (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base	(b) Amount of s	sales and base	Fee	es and other commission	s paid				
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base Fees and other commissions paid					(d) Purpose			(e) Organization code	
(b) Amount of sales and base Fees and other commissions paid		1266	17 B	ROKER BONUS				3	
(b) Amount of sales and base		(a) Nam	e and address of the agent, broker,	or other person to whor	n commi	ssions or fees	were paid		
(b) Amount of sales and base									
	(h) Amount of s	sales and base	Fee	es and other commission	s paid				
			(c) Amount		d) Purpo	ose		(e) Organization code	

Schedule A (Form 5500)	2017	Page 2 – [1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base	Fees and other commissions paid			(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>, </u>	code
(1)				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi- this report.	dual contrac	cts with each carrier may	be treated	I as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year er		5		
		tracts With Allocated Funds:				
-	а	State the basis of premium rates				
	_	otato dio sado di promini ratos				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor				
	u	retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participat	ion guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶		-		
		(5) U guaranteed investment (4) U other 7				
				ı		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 7c(5)			
)				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).		İ	7d	
		Deductions:	Γ			
	•	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(3)			
		(4) Outer (specify below)	. / C (+)			
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		i	7f	

ı	Page	4

F	Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the same employer(s) or members of the information may be combined for reporting purposes if such contracts are experience-rated as a unit. It employees, the entire group of such individual contracts with each carrier may be treated as a unit for purpose.							ontracts cover individual	,
8	Ber	efit a	nd contract type (check all applicable boxes)						
	а	ПНе	ealth (other than dental or vision)	b Dental	с	Vision		d X Life insurance	
	е	_	emporary disability (accident and sickness)	f Long-term disabilit	<u> </u>	Supplemental unem	nlovment	h Prescription drug	
				<u> </u>	` . .	<u> </u>	pioyment	<u> </u>	
	Ī	_	op loss (large deductible)	j HMO contract	K_	PPO contract		I Indemnity contract	
	m	Ot	her (specify)						
_									
9			ce-rated contracts:	!	- (1)				
	а		iums: (1) Amount received		9a(1)				
			ncrease (decrease) in amount due but unpaid						
			ncrease (decrease) in unearned premium res	•			0-(4)		
	L	, ,	arned ((1) + (2) - (3))				. 9a(4)		
	b		efit charges (1) Claims paid						
			ncrease (decrease) in claim reserves				01- (0)		
			ncurred claims (add (1) and (2))						
	_	` '	Claims charged(1) Betarties absence (2)				. 9b(4)		
	С		nainder of premium: (1) Retention charges (c	, i	00/41//41				
			(A) Commissions		9c(1)(A) 9c(1)(B)				
			(B) Administrative service or other fees		9c(1)(C)				
			(C) Other specific acquisition costs(D) Other expenses						
			(E) Taxes		a (4)(=)				
			(F) Charges for risks or other contingencies.						
			(G) Other retention charges		0.74\70\				
			(H) Total retention				9c(1)(H)	
			Dividends or retroactive rate refunds. (These	_					
	d		us of policyholder reserves at end of year: (1	<u>—</u>					
	u		Claim reserves				9d(1)		
		` '	Other reserves						
	е	` '	dends or retroactive rate refunds due. (Do n						
10			erience-rated contracts:	or include amount enteree	2 111 1111C 3C(2)	.)	., 30		
•	a		al premiums or subscription charges paid to o	arrier			. 10a		8438
	b		e carrier, service, or other organization incur				100		0 100
		rete	ntion of the contract or policy, other than repeature of costs.	, .		•	. 10b		
P	Part	IV	Provision of Information						
				notion nonconstrute as	oto Cobodula	Л	Yes	X No	
11			insurance company fail to provide any inform		ete Schedule	9 A?	162	NU INU	
12	∠ If	the an	nswer to line 11 is "Yes," specify the informat	on not provided.					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

OMB No. 1210-0110

nurquent to EDICA coetion 402(a)(2)							m is Open to Public Inspection
For calendar plan year 20	17 or fiscal pla	n year beginning 02/01/2017		and en	nding 01/31	/2018	
A Name of plan THE ARC JACKSONVILL	.E				ee-digit n number (PN)) •	501
C Plan sponsor's name a THE ARC JACKSONVILL	E			59-	oyer Identifica -6209603		
on a separa		rning Insurance Contrac L. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca HEALTH OPTIONS, INC	rrier				1		
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate nu persons covered a		(5)	Policy or confirmation	ontract year
50.0400000			policy or contract	-			(g) To
59-2403696	95089	59849	80		02/01/2017		01/31/2018
2 Insurance fee and communication descending order of the		ation. Enter the total fees and to	otal commissions paid. Li	st in line 3	the agents, b	rokers, and o	ther persons in
(a) Total a	amount of com			(b) To	otal amount o	f fees paid	
		30880					
3 Persons receiving com	missions and f	ees. (Complete as many entrie	s as needed to report all	persons).			
	(a) Name a	and address of the agent, broke				were paid	
MFB FINANCIAL, INC		SUITE	PLANTATION ISLAND D E 210 T AUGUSTINE, FL 32080				
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose			(e) Organization code
	30880						3
	(a) Name a	and address of the agent, broke	r, or other person to whor	n commiss	sions or fees v	were paid	
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpos	se		(e) Organization code

Schedule A (Form 5500)	2017	Page 2 – [1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base	Fees and other commissions paid			(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>, </u>	code
(1)				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi- this report.	dual contrac	cts with each carrier may	be treated	I as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year er		5		
		tracts With Allocated Funds:				
-	а	State the basis of premium rates				
	_	otato dio sado di promini ratos				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor				
	u	retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participat	ion guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶		-		
		(5) U guaranteed investment (4) U other 7				
				ı		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 7c(5)			
)				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).		İ	7d	
		Deductions:	Γ			
	•	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(3)			
		(4) Outer (specify below)	. / C (+)			
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		i	7f	

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F	Part III Welfare Benefit Contract Informat If more than one contract covers the same gr the information may be combined for reportin employees, the entire group of such individual	oup of employees of the sig purposes if such contra	icts are exp	perience-rated as a unit	. Where co	ontracts cover individual	
8	Benefit and contract type (check all applicable boxes)	_		_		_	
	a Health (other than dental or vision)	b Dental	С	Vision		d Life insurance	
	e Temporary disability (accident and sickness)	f Long-term disability	g	Supplemental unemp	oloyment	h X Prescription drug	
		j X HMO contract	k [·	I Indemnity contract	
		, A rame consucer] • •••••••			
	m ☐ Other (specify) ▶						
a	Experience-rated contracts:						
•	a Premiums: (1) Amount received		9a(1)		514667		
	(2) Increase (decrease) in amount due but unpaid.	F	9a(2)		314001		
	(3) Increase (decrease) in unearned premium rese		9a(3)				
	(4) Earned ((1) + (2) - (3))	_		<u> </u>	9a(4)	5146	67
	b Benefit charges (1) Claims paid		9b(1)				
	(2) Increase (decrease) in claim reserves		9b(2)				
	(3) Incurred claims (add (1) and (2))				9b(3)		_
	(4) Claims charged				9b(4)	4139	98
	C Remainder of premium: (1) Retention charges (on						
	(A) Commissions		9c(1)(A)		30880		
	(B) Administrative service or other fees		9c(1)(B)				
	(C) Other specific acquisition costs		9c(1)(C)				
	(D) Other expenses		9c(1)(D)		54349		
	(E) Taxes		9c(1)(E)		0		
	(F) Charges for risks or other contingencies		9c(1)(F)		15440		
	(G) Other retention charges		9c(1)(G)		T		
	(H) Total retention	<u></u>	<u></u> .		9c(1)(H)	1006	69
	(2) Dividends or retroactive rate refunds. (These a	amounts were paid in c	cash, or	credited.)	9c(2)		
	d Status of policyholder reserves at end of year: (1)	Amount held to provide be	enefits after	r retirement	9d(1)		
	(2) Claim reserves				9d(2)		
	(3) Other reserves				9d(3)		
	e Dividends or retroactive rate refunds due. (Do not	include amount entered i	n line 9c(2)) .)	9e		
10	Nonexperience-rated contracts:				<u> </u>		
	a Total premiums or subscription charges paid to ca	rrier			10a		
	b If the carrier, service, or other organization incurre	, .		•			
	retention of the contract or policy, other than repor Specify nature of costs.	ted in Part I, line 2 above,	, report amo	ount	10b		
	Part IV Provision of Information				.,		
11	1 / 1 /		te Schedule	e A?	Yes	X No	
12	2 If the answer to line 11 is "Yes," specify the information	n not provided.					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

pursuant to ERISA section 103(a)(2).						Inspection	
For calendar plan year 201	17 or fiscal plan	year beginning 02/01/2017		and en	ding 01/3	1/2018	
A Name of plan THE ARC JACKSONVILL	E				e-digit number (PN	1) •	501
C Plan sponsor's name a THE ARC JACKSONVILL		e 2a of Form 5500			yer Identifica 6209603	ation Number (EIN)
		ning Insurance Contract Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance car STANDARD LIFE & ACCID							
41 EIN	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ntract year
(b) EIN	code	identification number	persons covered at policy or contract		(f)	From	(g) To
73-0994234	86355	13335	23		02/01/2017	7	01/31/2018
2 Insurance fee and commodescending order of the		tion. Enter the total fees and tota	I commissions paid. Lis	st in line 3	the agents, l	brokers, and ot	her persons in
(a) Total a	mount of comr	nissions paid		(b) To	tal amount o	of fees paid	
		6047					
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all p	persons).			
	(a) Name a	nd address of the agent, broker, o	or other person to whom	n commiss	ions or fees	were paid	
MWL		PO BOX JACKSO	(14067 DN, MS 39236				
(b) Amount of sales an	nd base	Fees	and other commission	s paid			
commissions pai	d	(c) Amount		(d) Purpose			(e) Organization code
	1513						3
	(a) Name a	nd address of the agent, broker, o	or other person to whom	n commiss	ions or fees	were paid	
MARK BAILEY 1200 PLANTATION ISLAND DRIVE S SAINT AUGUSTINE, FL 32080							
(b) Amount of sales an	nd base	Fees	and other commission	s paid			
commissions pai		(c) Amount		(d) Purpose	9		(e) Organization code
	4534						3
For Paperwork Reduction	n Act Notice, s	see the Instructions for Form 5	500.			Sched	lule A (Form 5500) 2017

Schedule A (Form 5500)	2017	Page 2 – [1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>, </u>	code
(1)				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi- this report.	dual contrac	cts with each carrier may	be treated	I as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year er			5	
		tracts With Allocated Funds:				
-	а	State the basis of premium rates				
	_	otato dio sado di promini ratos				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor				
	u	retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participat	ion guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶		-		
		(5) U guaranteed investment (4) U other 7				
				ı		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 7c(5)			
)				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).		İ	7d	
		Deductions:	Γ			
	•	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(3)			
		(4) Outer (specify below)	. / C (+)			
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		i	7f	

ı	Page	4

P	art	III	Welfare Benefit Contract Inform If more than one contract covers the same the information may be combined for repor employees, the entire group of such individ	group of employ ting purposes if s	such contra	acts are expe	erience-rated as a ur	nit. Where c	ontracts cover	
8	Ben	efit a	nd contract type (check all applicable boxes)							
	а	He	ealth (other than dental or vision)	b Dental		С	Vision		d Life ins	urance
	е	Te	mporary disability (accident and sickness)	f Long-teri	rm disability	g	Supplemental uner	mployment	h Prescri	ption drug
	i İ		op loss (large deductible)	j HMO cor	•	~	PPO contract	, ,		ity contract
	m		her (specify) PSMEDICAL/COPAY/BUY		iiiiaot		111000111111111			mry contract
		<u> </u>	riei (specily) Prawedical/COPAT/BOT	JF						
9	Evn	oriona	ce-rated contracts:							
•	•		iums: (1) Amount received			9a(1)				
	u		ncrease (decrease) in amount due but unpai		-	9a(2)			_	
			ncrease (decrease) in unearned premium re			• • • •				
			arned ((1) + (2) - (3))		_			9a(4)		
	b	` '	efit charges (1) Claims paid		_			1 7		
			ncrease (decrease) in claim reserves							
			ncurred claims (add (1) and (2))					9b(3)		
			laims charged					(1)		
	C	Ren	nainder of premium: (1) Retention charges (n an accrual ba	asis)					
		((A) Commissions			9c(1)(A)				
		((B) Administrative service or other fees			9c(1)(B)				
		((C) Other specific acquisition costs		<u> </u>	9c(1)(C)				
			(D) Other expenses			9c(1)(D)				
			(E) Taxes			9c(1)(E)				
			(F) Charges for risks or other contingencies							
		((G) Other retention charges			9c(1)(G)			-	
			(H) Total retention	F	_	_)	
		(2) [Dividends or retroactive rate refunds. (These	amounts were	paid in	cash, or	credited.)	9c(2)		
	d	Stat	us of policyholder reserves at end of year: (*) Amount held to	to provide b	enefits after	retirement	9d(1)		
		(2) (Claim reserves							
		` '	Other reserves							
			dends or retroactive rate refunds due. (Do n	ot include amou	ınt entered	in line 9c(2) .	.)	9e		
10	_		erience-rated contracts:					40		
	а		Il premiums or subscription charges paid to					<u>10a</u>		30239
	b	rete	e carrier, service, or other organization incur ntion of the contract or policy, other than rep					10b		
			Drovinion of Information							
Р	art	IV	Provision of Information				-			
11	Di	d the	insurance company fail to provide any inforn	nation necessary	y to comple	te Schedule	A?	Yes	X No	
12	l If t	he ar	swer to line 11 is "Yes," specify the information	ion not provided	d.)					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

pursuant to ERISA section 103(a)(2). Inspection						
For calendar plan year 20	17 or fiscal plan	year beginning 02/01/2017	and en	iding 01/31/2018	•	
A Name of plan THE ARC JACKSONVILL	_E			e-digit number (PN)	501	
C Plan sponsor's name a		e 2a of Form 5500	· ·	oyer Identification Number 6209603	(EIN)	
		ning Insurance Contract Individual contracts grouped as				
1 Coverage Information:						
(a) Name of insurance ca STANDARD LIFE & ACCII						
4) 501	(c) NAIC	(d) Contract or	(e) Approximate number of	Policy or	contract year	
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	(g) To	
73-0994234	86355	13335	7	02/01/2017	01/31/2018	
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	commissions paid. List in line 3	the agents, brokers, and	other persons in	
(a) Total	(a) Total amount of commissions paid (b) Total amount of fees paid					
		697				
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	is needed to report all persons).			
	(a) Name a	nd address of the agent, broker, o	or other person to whom commiss	ions or fees were paid		
MWL		PO BOX JACKSC	(14067 DN, MS 39236			
(b) Amount of sales a	nd base	Fees	and other commissions paid			
commissions pa		(c) Amount	(d) Purpose	(e) Organization code		
174					3	
	(a) Name a	nd address of the agent, broker, o	or other person to whom commiss	ions or fees were paid		
MARK BAILEY		1200 PL	ANTATION ISLAND DRIVE S JUGUSTINE, FL 32080	•		
(b) Amount of colors	ad bass	Fees	and other commissions paid			
(b) Amount of sales as commissions pa		(c) Amount	•	(d) Purpose		
	523				(e) Organization code	
For Panerwork Reduction	on Act Notice	see the Instructions for Form 55	500	Sch	edule A (Form 5500) 2017	

Schedule A (Form 5500)	2017	Page 2 – [1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,		code
(1)				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi- this report.	dual contrac	cts with each carrier may	be treated	I as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year er			5	
		tracts With Allocated Funds:				
-	а	State the basis of premium rates				
	_	otato dio suoio di promini rutos				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor				
	u	retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participat	ion guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶		-		
		(5) U guaranteed investment (4) U other 7				
				ı		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 7c(5)			
)				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).		İ	7d	
		Deductions:	Γ			
	•	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(3)			
		(4) Outer (specify below)	. / C (+)			
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		i	7f	

ı	Page	4

Р	art							
		If more than one contract covers the same the information may be combined for repor employees, the entire group of such individual.	ting purposes if such cont	racts are exp	périence-rated as a ur	nit. Where co	ontracts cover individual	
8	Ben	efit and contract type (check all applicable boxes)					·	_
	a	Health (other than dental or vision)	b Dental	с	Vision		d Life insurance	
	L		<u>.</u>	L				
	e	Temporary disability (accident and sickness)	f Long-term disabili		Supplemental uner	npioyment	h Prescription drug	
	İ	Stop loss (large deductible)	j HMO contract	κL	PPO contract		I Indemnity contract	
	m	X Other (specify) ▶ PSMEDICAL/COPAY/BUY I	JP II					
9	Exp	erience-rated contracts:		•				
	а	Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid	b	9a(2)				
		(3) Increase (decrease) in unearned premium res				1		
		(4) Earned ((1) + (2) - (3))				9a(4)		
	b	Benefit charges (1) Claims paid						
		(2) Increase (decrease) in claim reserves				21 (2)		
		(3) Incurred claims (add (1) and (2))						
	_	(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (c	·	0-(4)(A)				
		(A) Commissions		9c(1)(A)			_	
		(B) Administrative service or other fees		9c(1)(B) 9c(1)(C)				
		(C) Other specific acquisition costs		0.741701				
		(D) Other expenses		0 (4)(5)				
		(E) Taxes(F) Charges for risks or other contingencies.						
		(G) Other retention charges						
		(H) Total retention				9c(1)(H)	1	
		(2) Dividends or retroactive rate refunds. (These					/	
	d	Status of policyholder reserves at end of year: (1	_					
	u	(2) Claim reserves				9d(1)		
		(3) Other reserves						_
	е	Dividends or retroactive rate refunds due. (Do n						
10	_	nexperience-rated contracts:	<u> </u>		<i>,</i> ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,		
	а	Total premiums or subscription charges paid to o	carrier			10a	34	487
	b	If the carrier, service, or other organization incur						
	~	retention of the contract or policy, other than rep	, ,		•	10b		
	Spe	cify nature of costs.						
_								
P	art				-	1		
11	Die	the insurance company fail to provide any inform	nation necessary to compl	ete Schedul	e A?	Yes	X No	
12	lf t	he answer to line 11 is "Yes," specify the informat	ion not provided.					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

OMB No. 1210-0110

pursuant to ERISA section 103(a)(2). This Form is Open to Public Inspection						•	
For calendar plan year 20	17 or fiscal pla	n year beginning 02/01/2017		and en	nding 01/31	/2018	
A Name of plan THE ARC JACKSONVILL	E				e-digit number (PN) >	501
THE ARC JACKSONVILL	C Plan sponsor's name as shown on line 2a of Form 5500 THE ARC JACKSONVILLE D Employer Identification Number (EIN) 59-6209603						
on a separa		rning Insurance Contract A. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca	rrier				ı	Deliana	
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate nu persons covered a	t end of	(f)	From	ontract year (g) To
82-2723296	60380			policy or contract year 53			01/31/2018
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	otal commissions paid. Li	st in line 3	the agents, b	rokers, and o	I ther persons in
(a) Total a	amount of com	nmissions paid		(b) To	otal amount o	f fees paid	
		5245					47
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).			
	(a) Name	and address of the agent, broke	r, or other person to who	m commiss	sions or fees	vere paid	
JEFFERY M SINTAY			ALCOVA RIDGE DR VEGAS, NV 89135				
(b) Amount of sales ar	nd hase	F	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose	е		(e) Organization code
	3						3
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	sions or fees	vere paid	
ROBERT P FERRONE 1701 WILLIAMS CT APT 202 COLUMBUS, GA 31904							
(b) Amount of sales ar			ees and other commission				
commissions pa		(c) Amount		(d) Purpose	e		(e) Organization code
3							3

Schedule A (Form 5500)	2017	Page 2 – 1	
VICKI M DICKERT	258 S	e, or other person to whom commissions or fees were paid EAVIEW AVE ONA BEACH, FL 32118	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid 4	(C) Amount	(u) Fulpose	code 3
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
CECIL T SALMON	95 EC PALM	DWARD DR I COAST, FL 32164	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
5			3
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
J C ADAMS INC	5631	NE 31ST TER A, FL 34479	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
7			3
(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid	
ROBERT L TRAPNELL JR	15 N I APT 7	NDIAN RIVER DR	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
7			3
()))	and address of the second L		
LYNN M SPEARS	928 C	c, or other person to whom commissions or fees were paid COLLINSWOOD DR SONVILLE, FL 32225	
(h) Amount of calca and base		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
9			3

Page 2 -	2	

(a) Nar	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
BRANDON C ADAMS		ROWN COLONY RD	
	SAINT	Γ AUGUSTINE, FL 32092	
			(a)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
10			3
(a) Nar	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
JAMES R MIRABELLI	21426	GOSIER WAY	
	BOCA	A RATON, FL 33428	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
10			3
(a) Nar	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
DONALD MCELROY	4825 (CISCO DR W	
	JACKS	SONVILLE, FL 32219	
		Fees and other commissions paid	(e)
(b) Amount of sales and base		Organization	
commissions paid	(c) Amount	(d) Purpose	code
12			3
· · · · · · · · · · · · · · · · · · ·	G .	, or other person to whom commissions or fees were paid	
JIMMY LEON JOHNSON	APT 1	BELLA VISTA BLVD 19	
	ST AU	JGUSTINE, FL 32084	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(O) / WHO GITE	(a) 1 diposo	code 3
20			3
		, or other person to whom commissions or fees were paid	
TROY DANIEL DESLATTE		HADY PARK DR YETTE, LA 70508	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(-)	(-) - 5.655	code 3
20			J

		(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
38			3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

MARK A LINSNER

10175 FORTUNE PKWY UNIT 604 JACKSONVILLE, FL 32256

		(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
45			3

69

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

ROBERT MARION KNIGHT

2703 OCEAN DR S JACKSONVILLE BEACH, FL 32250

	Fees and other commissions paid				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
82			3		

Page Z - 5

(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid		
JAMEY MILLER INC	4811 I	BEACH BLVD		
	STE 1			
	JACK	SONVILLE, FL 32207		
		Face and other commissions and	(2)	
(b) Amount of color and base		Fees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
		, , , , , , , , , , , , , , , , , , ,	3	
244			3	
(a) Nor	no and address of the agent broker	, or other person to whom commissions or fees were paid		
DAVID MARKS		WE HECK CT BLDG J N ROUGE, LA 70816		
	BATO	IN ROUGE, LA 70010		
		Fees and other commissions paid	(e)	
(b) Amount of sales and base		·	Organization	
commissions paid	(c) Amount	(d) Purpose	code	
252			3	
(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid		
DAVID ABOULAFIA	1 SPF	NCER ST		
27.17.2 7.2 G G Z W W C	SAINT	AUGUSTINE, FL 32084		
(b) Amount of calco and back		Fees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
1033	7		3	
(-) N-	and address of the areast headen			
		, or other person to whom commissions or fees were paid		
SUSAN KNIGHT INS SERV INC		OCEAN DR S 2ND FL		
	JACK	SONVILLE BEACH, FL 32209		
		Fees and other commissions paid	(e)	
(b) Amount of sales and base			Organization	
commissions paid	(c) Amount	(d) Purpose	code	
3095	34		3	
(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid		
	-	·		
(In) Assessment (In)		Fees and other commissions paid	(e)	
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization	
commissions paid	(5) /	(a) i diposo	code	

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi- this report.	dual contrac	cts with each carrier may	be treated	I as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year er			5	
		tracts With Allocated Funds:				
-	а	State the basis of premium rates				
	_	otato dio suoio di promini rutos				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor				
	u	retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participat	ion guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶		-		
		(5) U guaranteed investment (4) U other 7				
				ı		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 7c(5)			
)				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).		İ	7d	
		Deductions:	Γ			
	•	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(3)			
		(4) Outer (specify below)	. / C (+)			
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		i	7f	

ı	Page	4

P	art l	III Welfare Benefit Contract Informa	tion					
		If more than one contract covers the same g the information may be combined for reporti employees, the entire group of such individu	ng purposes if such conti	racts are exp	erience-rated as a uni	t. Where co	ntracts cover indivi	
8	Bene	efit and contract type (check all applicable boxes)		-	<u> </u>			
	аΓ		b Dental	с	Vision		d Life insurance	:e
	느		f Long-term disabilit	<u> </u>	Supplemental unem	nlaumant	h Prescription	
	e [· - =	1	pioyment		-
	י ו	Stop loss (large deductible)	j HMO contract	k_	PPO contract		I Indemnity co	ntract
	m	Other (specify) ► WORKSITE/SUPPLEMENTA	.L					
							1	
		erience-rated contracts:	,	- (1)				
		Premiums: (1) Amount received	ľ	9a(1)				
		(2) Increase (decrease) in amount due but unpaid		9a(2)				
		(3) Increase (decrease) in unearned premium rese				0=(4)		
	_	(4) Earned ((1) + (2) - (3))				. 9a(4)		
		Benefit charges (1) Claims paid	ľ	(-)				
		(2) Increase (decrease) in claim reserves				. 9b(3)		
		(4) Claims charged				9b(3)		
		Remainder of premium: (1) Retention charges (or				. JD(T)		
	C	(A) Commissions	·	9c(1)(A)				
		(B) Administrative service or other fees	ľ	9c(1)(B)				
		(C) Other specific acquisition costs	ŀ	9c(1)(C)				
		(D) Other expenses	ľ	0 (4)(D)				
		(E) Taxes		0 (4)(5)				
		(F) Charges for risks or other contingencies						
		(G) Other retention charges		9c(1)(G)				
		(H) Total retention				9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1)		_		9d(1)		
		(2) Claim reserves				. 9d(2)		
		(3) Other reserves				. 9d(3)		
	е	Dividends or retroactive rate refunds due. (Do no	t include amount entered	d in line 9c(2)	.)	. 9e		
10	No	onexperience-rated contracts:						
	а	Total premiums or subscription charges paid to ca	arrier			. 10a		35315
	b	If the carrier, service, or other organization incurre retention of the contract or policy, other than repo				. 10b		
	Spe	ecify nature of costs.	ited in Part I, line 2 abovi	е, героп атс	ount	100		
P	art I	IV Provision of Information						
						V	V Na	
		d the insurance company fail to provide any informa		ete Schedule	e A?	Yes	X No	
12	If th	he answer to line 11 is "Yes," specify the information	on not provided.					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

OMB No. 1210-0110

pursuant to ERISA section 103(a)(2).						orm is Open to Public Inspection			
For calendar plan y	ear 2017 or fisca	ıl plan	year beginning 02/01/2017		ar	nd ending	01/31/2018		
A Name of plan THE ARC JACKSO	ONVILLE					Three-digit plan numbe	r (PN)	<u> </u>	501
C Plan sponsor's r		on line	e 2a of Form 5500		D E	mployer Ide 59-620960		umbe	r (EIN)
on a	separate Sched	ncer ule A	ning Insurance Contrac . Individual contracts grouped a	t Coverage, Fees, as a unit in Parts II and II	and (Commiss be reported of	ions Provi on a single S	de inf Sched	ormation for each contract ule A.
1 Coverage Inform (a) Name of insura THE LINCOLN NAT	nce carrier	URAI	NCE COMPANY						
(b) EIN	(c) N/		(d) Contract or identification number	(e) Approximate no persons covered a	at end o		Poli (f) From	cy or	contract year (g) To
35-0472300	65676		000400172463		policy or contract year 56 02/		/2017		01/31/2018
Insurance fee ar descending orde			ation. Enter the total fees and to	tal commissions paid. L	ist in li	ne 3 the age	ents, brokers	s, and	other persons in
(a) Total amount of commissions paid (b) Total amount of fees paid									
531 14									
3 Persons receivir	ng commissions	and fe	ees. (Complete as many entries	s as needed to report all	persor	ns).			
		me a	nd address of the agent, broker			missions or	fees were p	aid	
MFB FINANCIAL IN	C		STE 2	PLANTATION ISLAND D 10 AUGUSTINE, FL 3208					
(b) Amount of s	ales and base		Fe	es and other commissio	ns paic	b			
commissions paid (c) Amount					(d) Pu	rpose			(e) Organization code
	53°		14 B	ROKER BONUS					3
	(a) Na	me a	nd address of the agent, broker	, or other person to who	m com	missions or	fees were p	aid	
(b) Amount of s	ales and base		Fe	es and other commissio	ns paid	d			
commissi			(c) Amount		(d) Pu	rpose			(e) Organization code
			cos the Instructions for Form	5500				0 :	odulo A (Form FF00) 2047

Schedule A (Form 5500)	2017	Page 2 – [1		
(a) No.			omicciono ar foco ware noid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid		
4.1.		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
	<u> </u>			(e)	
(b) Amount of sales and base	Fees and other commissions paid unt of sales and base				
commissions paid	(c) Amount	(1	d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
		Fees and other commissions p	naid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code	
commissions paid		,	<u>, </u>	code	
(1)					
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
Fees and other commissions paid					
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	dual contrac	cts with each carrier may	be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year er	5			
		tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrierPremiums due but unpaid at the end of the year				
	C					
	d	If the carrier, service, or other organization incurred any specific costs in cor			6c	
	<u>.</u>	retention of the contract or policy, enter amount		6d		
		Specify nature of costs	•			
· · · · · · · · · · · · · · · · · · ·						
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	_			. \Box		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin				
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai	intained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participat	ion guarantee		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	7c(1)		7.0	
	•	(2) Dividends and credits	7c(1)			
			7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 10(3)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		>				
					7-75	
	(5) Total deductions				7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7 f	

ı	Page	4

Р	art	III Welfare Benefit Contract Inform	ation						
		If more than one contract covers the same the information may be combined for repor employees, the entire group of such individual.	ting purposes if such cont	racts are exp	perience-rated as a ur	nit. Where co	intracts cover individual		
8	Ben	efit and contract type (check all applicable boxes)		-	·	-	· · ·		
	a	Health (other than dental or vision)	b Dental	c 5	X Vision		d Life insurance		
	L		=	<u> </u>	=	nnlaumant			
	e	Temporary disability (accident and sickness)	f Long-term disabilit	- 5	Supplemental uner	прюуттепт	h Prescription drug		
	İ	Stop loss (large deductible)	j HMO contract	k [PPO contract		I Indemnity contract		
	m	Other (specify)							
9	Exp	erience-rated contracts:		•	1				
	а	Premiums: (1) Amount received	ļ	9a(1)					
		(2) Increase (decrease) in amount due but unpaid	t	9a(2)					
		(3) Increase (decrease) in unearned premium res	serve	9a(3)					
		(4) Earned ((1) + (2) - (3))	i		 T	9a(4)			
	b	Benefit charges (1) Claims paid					_		
		(2) Increase (decrease) in claim reserves	· ·						
		(3) Incurred claims (add (1) and (2))							
		(4) Claims charged				9b(4)			
	С	Remainder of premium: (1) Retention charges (c	•		1		_		
		(A) Commissions		9c(1)(A)			_		
		(B) Administrative service or other fees		9c(1)(B)			_		
		(C) Other specific acquisition costs		9c(1)(C)			_		
		(D) Other expenses					_		
		(E) Charge for right an other continuous					-		
		(F) Charges for risks or other contingencies. (G) Other retention charges					-		
			•			9c(1)(H)			
		(H) Total retention							
	لہ	(2) Dividends or retroactive rate refunds. (These amounts were paid in cas							
	d	Status of policyholder reserves at end of year: (1				` `			
		(2) Claim reserves				9d(2)	+		
	е	(3) Other reserves Dividends or retroactive rate refunds due. (Do n				` `			
10	_	nexperience-rated contracts:	ot include amount entered	1 111 1111e 30(2	<i>]</i> .)	36			
10	a	Total premiums or subscription charges paid to o	carrier			10a	5310		
	-					104	3310		
	b	If the carrier, service, or other organization incur retention of the contract or policy, other than rep				10b			
	Spe	cify nature of costs.	sited in Fait I, into 2 abov	o, roport am					
Part IV Provision of Information									
			nation necessary to comple	ata Schadul	ο Δ2	Yes	X No		
	The state measures company take provide any measurements of the state								
12	12 If the answer to line 11 is "Yes," specify the information not provided.								